



Coral A. Quiet, MD

Robert R. Kuske, MD

Authorization to Release Protected Health Information

Patient Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Date of Birth: _____

I authorize the use and/or release of my protected health information as described below. I understand that the information used or released as a result of this Authorization may no longer be protected by federal privacy laws and may be further used or released by persons or organizations receiving it without obtaining my authorization. I have the right to revoke this Authorization by providing written notice to Arizona Breast Cancer Specialists. Revocation of this Authorization will not affect any action taken before receipt of the written revocation.

Release Protected Health Information

TO: Arizona Breast Cancer Specialists
9055 E. Del Camino Dr., Suite 200
Scottsdale, AZ 85258
FAX: 480.922.5231

FROM: Arizona Oncology Services
16620 N 40th St C-2
Phoenix, AZ

Arizona Oncology Services
8994 E. Desert Cove Ave
Scottsdale, AZ

For the following date(s) or timeframe: From _____ To: Present or _____

Health information to release includes the following (as checked):

- Entire Record including consultation and follow-up notes, radiology results, physics/dosimetry data, and complete treatment record.
- Records from outside physicians that were copied to Dr. Kuske or Dr. Quiet.
- I give special permission to release any information regarding: (Initial on applicable line(s) only)
 _____ Substance Abuse _____ Psychiatric/Mental Health Information _____ HIV Information

Purpose: (Check applicable categories)

- Further Medical Care Patient's Request Insurance Eligibility/Benefits
- Disability Determination Legal Investigation Other:

Expiration Date and Other Information:

This authorization will expire on _____. If I do not indicate a date, this will expire one (1) year from the date of my signature. A photocopy of this authorization is as valid as the original. I understand this authorization is voluntary. I am confirming my authorization that the health care provider may use and/or disclose to the persons and/or organizations named in this form the protected health information described above. I understand that no person or entity authorized to use or disclose health care information may condition treatment, payment, enrollment or eligibility for benefits on whether I sign this Authorization.

Signature

Date